Medicare's Early Months: A Program Round-Up

by ARTHUR E. HESS*

WHEN MEDICARE went into effect on July 1, 1966, President Johnson paid high tribute to the many individuals in the private and governmental sectors that participated in its planning by noting that the program has called for more extensive preparations than any similar peacetime effort in the history of the Nation. Passed by Congress only 11 months earlier, the health insurance program for the aged called for the creation of comprehensive administrative machinery. Before the first benefit could be paid, working relationships had to be established among the Social Security Administration and other participating Federal and State agencies, the providers of health care, carriers and intermediaries, and the insured elderly.

Involved initially were the staffs of some 6,500 participating hospitals, the personnel of some 1,200 participating home health agencies, 74 Blue Cross organizations, 33 Blue Shield plans, 15 insurance companies, 1 independent health insurer, and over 100 group practice prepayment plans. On the government side, Medicare involved —besides the major components of the Social Security Administration — the Public Health Service, the Welfare Administration, and State health and welfare agencies.

Policy and procedures had to be established and regulations developed and issued. The Social Security Administration convened eight work groups of outside experts—one in each of the most difficult technical areas to assist in policy and procedures development. The Health Insurance Benefits Advisory Council, comprised of persons outstanding in medical, hospital, and other health-related fields, reviewed every significant policy in depth and made recommendations.

Obviously, in an undertaking of this magnitude, the evolution of procedures, forms, policies, methods, and systems were only first steps toward implementing the program. It was also necessary to seek the cooperation of thousands of people whose attitudes would help determine Medicare's success or failure. The following actions were taken:

—Employees of the Social Security Administration's district offices received training in the health insurance program to enable them to answer questions and provide claims assistance.

—Each one of the Nation's hospitals received a variety of materials including a copy of the quality standards for participation in the program, guidelines for meeting the Civil Rights Act requirements, an application for certification, a detailed statement of the principles of reimbursement of hospitals and of hospital-based physicians, and an operating manual giving detailed information on procedures and policy.

—A handbook for physicians, containing a general description of the hospital and medical programs and a more detailed explanation of those parts of particular interest to the practicing physician, was distributed to more than 250,000 physicians.

—By means of several mailings and personal visits, America's 19 million aged persons were informed of the benefits available to them under the two-part program. As of July 1, 1966, about 18.9 million persons aged 65 or over were entitled to hospitalization benefits under Part A and 17.6 million had voluntarily enrolled for medical coverage at a premium rate of $3 a month (matched by $3 monthly from general revenues).

—A White House Conference on the Implementation of Medicare was held, followed by meetings throughout the country with local medical societies and smaller groups of physicians. The objective of these sessions was to give to doctors and to the members of their staffs an opportunity to obtain answers to any questions they might have regarding the operation of the program.

—Briefing sessions were held with members of both Houses of Congress to provide them with information on the steps that had been taken to put Medicare into effect. Press conferences were held in 72 locations throughout the country just before the program was to become effective to inform the public and the local hospital and medical officials of the progress made in implementing the program.

BRINGING PROVIDERS INTO THE PROGRAM

Quality standards for facilities desiring to participate in the program were developed with the help of the Public Health Service. The Social Security Administration then entered into agreements with State agencies—usually public health agencies—to secure their assistance in administering this phase of the program. These agencies

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surveyed hospitals that did not have accreditation from the Joint Commission on Accreditation of Hospitals, extended-care facilities, home health agencies, and independent laboratories to determine whether they met the standards. The State agencies also furnished consultative services to prospective providers to help them meet conditions for participation, and they will resurvey providers from time to time to assure that they continue to meet participation requests.

Hospitals

After 10 months of program operation, almost 6,800 hospitals with 98.5 percent of the bed capacity of non-Federal general care hospitals in the United States were participating.

Of the participating hospitals, more than 60 percent were accredited by the Joint Commission on Accreditation of Hospitals. Those accredited had only to establish an acceptable utilization review plan in order to participate. For some of the unaccredited, considerable upgrading of care and facilities had been required before July 1, 1966, to meet the standards.

During the first months, almost 400 hospitals in addition to those that started in the program, achieved participating status either by upgrading their care or by coming into compliance with title VI of the Civil Rights Act. At the end of the period, only about 55 hospitals that were found to meet the quality standards of the program did not have title VI clearance. Perhaps 100 more that might have been able to meet the standards did not apply, presumably because they did not yet meet title VI requirements.

Extended-Care Facilities

At the end of 10 months, just over 4,000 extended-care facilities with a capacity of more than 276,000 skilled nursing care beds were participating in the program—about half the Nation's total skilled nursing care bed capacity. It was estimated that the program required only about 65,000 at any given time. Although the total number of certified beds was sufficient, when viewed nationally we have not achieved the geographical availability needed.[1]

Home Health Agencies

Approximately 1,800 home health agencies were certified for participation in the program by the end of the first 10 months. Of these, about one-third were visiting nurse associations, another third were State and local agencies, and the remaining third were extended-care facility or hospital-based programs and a number of other types of arrangements for providing health services in the home.

To qualify as a home health agency under the program, agencies had to offer at least one health service in addition to skilled nursing care. Most of these participating agencies had added services in response to this requirement. (As late as 1963, no more than 250 agencies offered services beyond skilled nursing care.) Encouragingly, almost two-thirds of the participants offered two or more additional services. More than one-half furnished physical therapy services, more than a third offered home health aide services, approximately a third provided medical appliances and equipment, and about a fourth offered occupational or speech therapy.

Independent Laboratories

State agencies have certified 2,365 independent laboratories as being eligible to participate in the program. Some of the certifications, however, are conditional based upon certain technical personnel passing required proficiency examinations.

BRINGING THE BENEFITS TO THE AGED

The successful introduction of the Medicare program owes much to this careful preparation. The increase in utilization of hospital and extended care facilities by the elderly has been well within projections; the generally overcrowded conditions feared by many have not materialized.

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[1] See David Allen, "Health Insurance for the Aged: Participating Extended-Care Facilities," *Social Security Bulletin*, June 1967.

In order to meet the requirements for certification many health care facilities have upgraded the quality of their services. Near universal compliance with title VI of the Civil Rights Act of 1964, which denies Federal funds to segregated facilities, has led to better medical treatment for minority group members, regardless of age.

The successful introduction of the program also reflects the dedication and hard work of the staff of the private and governmental organizations who are involved in administering this program. Reimbursement for hospital and medical care to aged persons under two separate insurance programs involved the establishment of a new system for claims and benefit payment operations. Recognizing the need for obtaining data that would permit accurate measurement and evaluation of program effectiveness and provide a resource for future program decisions, the Social Security Administration began laying the foundation for an operating and statistical system before the program actually went into effect.[2] This system furnishes the means of obtaining extensive, systematic, and continuous information about the amount and kind of hospital and medical care services used by the aged, as well as the costs of such services.

A large body of data is being gathered and it is possible to begin to see something of the functioning of the program. In the sections that follow, the latest available data on the experience under Parts A and B of Medicare are presented.

Inpatient Hospital Services

During the first 10 months of Medicare, about 3¼ million aged persons received inpatient hospital services under Part A of the program. Due to the high readmission rate for this aged group, however, they accounted for about 4.4 million inpatient hospital admissions. The average stay per claim was slightly more than 13 days and the average hospital bill was about $575. Included in the count of claims are interim bills or claims requesting payment for part of an inpatient hospital stay so that the average length of stay per claim is therefore slightly less than the average per discharge.

Although it is too early to give precise figures, there is evidence that in the early months of Medicare a significant number of elderly persons entered hospitals for surgical procedures and other medical services they otherwise might not have received. This was most likely to be true of almost half the elderly who, before Medicare, had no health insurance protection.

Outpatient Hospital Services

By the end of April, approximately 2.8 million bills for outpatient hospital services had been received. Of these, some 1.5 million represented charges for outpatient diagnostic services and the remainder, about 1.3 million, were for outpatient therapeutic services.

Unfortunately, these figures are not a full measure of the volume of services rendered during the period in this area of health care. Benefit complexities have caused a lag in billing, and there are indications that some hospitals do not intend to bill for small charges that would be "deductible only."

Charges for outpatient therapeutic services are covered under the regular $50 medical insurance deductible and are reimbursable only when the insured's total covered expenses have exceeded this amount. Outpatient diagnostic charges, on the other hand, are subject to a $20 deductible under the hospital insurance program. Under the medical insurance program, this $20 is credited to the regular $50 deductible, except that, where the deductible has been met, it is a reimbursable expense.

Of the 1.5 million bills for outpatient diagnostic benefits received in the first 10 months of the program, approximately 40 percent exceeded $20 in amount and therefore resulted in payments under the hospital insurance program.

Extended-Care Services

From January 1, 1967, when the extended-care benefit became effective, to the end of April almost 130,000 notices of admission were recorded.

[2] For further particulars on the system see Howard West, "Health Incurance for the Aged: The Statistical Program," *Social Security Bulletin*, January 1967.

These notices are currently arriving at the rate of about 8,000 per week.

Although some of the initial admission notices relate to patients who could qualify even though they had been in extended-care facilities before January 1, 1966, an increasing percentage of them now represent people recently discharged from hospitals following the completion of intensive care. Thus we are beginning to realize one of the major objectives of the extended care benefit—the freeing of acute-care-hospital bed capacity as a result of the transfer of patients to nonhospital facilities suited to their post-acute-care needs.

Home Health Agency Services

In the first 10 months of the Medicare program, approximately 200,000 of the "start of care" notices were received from qualified agencies. About 65 percent of these notices represented services provided under the medical insurance program, which does not require prior hospitalization, and the remaining 35 percent represented services rendered to patients who had been hospitalized for at least 3 days.

The high percentage of the insured who received home health agency care without previously having been hospitalized strongly suggests that there are needs for home care services that, if met, will keep many elderly sick people out of hospitals.

Physician and Other Medical Services

By the end of April, nearly 20 million bills for medical services had been received by Part B carriers. Physicians' services accounted for over 90 percent of the bills received during the first 10 months. About 51 percent of these have been on assignment to physicians, suppliers, or providers on behalf of hospital-based physicians. Excluding bills for hospital-based physicians, the assignment rate was slightly more than 41 percent. Where the assignment method is used, the physician or other supplier of medical services agrees to accept the amount determined by the carrier to be a reasonable charge as the full charge for the services. At the 10-month point, almost 60 percent of the bills being processed resulted in a payment with the remaining 40 percent creditable toward the $50 deductible.

Because of time lags of varying duration in the receipt and payment of bills, it is not possible as yet to relate total billings to the number of persons involved. However, information on the actual use of and charges for covered medical services under the medical insurance program is available for the first 6 months of the program's operation from a continuing monthly Current Medical Survey (CMS).[3]

The medical insurance sample of the CMS is based on periodic household interviews of persons enrolled in the supplementary medical insurance program. On the basis of these interviews, it is estimated that by the end of the first 6 months of the health insurance program, about 12 million persons, or two-thirds of all medical insurance enrollees exposed to risk, used covered medical services and 4 million of these persons, or one-third, used sufficient services to meet the $50 deductible.

Benefit Payments

Reimbursements under the health insurance program are made through two separate trust funds. By the end of April 1967, over $1.9 billion in payments from the hospital insurance trust fund had been made on the basis of interim rates and subject to final cost verification.

Benefit payments from the supplementary medical insurance trust fund in the first 10 months amounted to over $462 million. This figure reflects lags in presentation by patients of their bills and some remaining processing lags.

Premium Collection

About 93 percent of those enrolled in the hospital insurance program, or approximately 17.6 million aged individuals, also enrolled in the medical insurance program, and current enrollment of persons reaching age 65 is also running a little higher than 90 percent.

The insured's $3 monthly premium for supplementary medical insurance is deducted from the monthly checks of the slightly more than 15 mil-

[3] For a complete description and first findings, see Jack C. Scharff; "Current Medicare Survey: The Medical Insurance Sample," *Social Security Bulletin*, April 1967.

lion of those enrollees who receive social security cash benefits, railroad retirement annuities or pensions, or Federal civil service annuities. The approximately 2.5 million enrollees not receiving monthly checks, and for whom deductions were not possible at the beginning of the program, were billed on a quarterly basis and paid their premiums by direct remittance.

Ninety-six percent of those billed paid the initial premium: 90 percent paid on the first notice; 6 percent after the first follow-up. About one-half of the 4 percent who failed to respond had died. Responses to the second quarterly premium notices indicate an even prompter rate of payment.

INTERMEDIARY AND CARRIER ACHIEVEMENT

During the initial 6 months of the program, intermediaries and carriers were undertaking a broad tooling-up effort involving the recruitment and training of personnel, development of systems, and refining organization.

Considerable progress has been made since January 1 by the intermediaries and carriers in reducing the average time lag between receipt and payment of bills. In respect to bills for physician services, the carriers on April 30, 1967, had an average of 2.6 weeks' work on hand, down from 4.9 weeks' work on hand in December and January. Bills were being paid in an average of 10 days or less in seven carrier service areas, and in 38 others the average bill-processing time is 11–21 days. About 75 percent of the 17.6 million elderly people enrolled in the medical insurance program live in the service areas where the average processing time is 21 days or less.

The Part A intermediaries had processed 7.5 million hospital bills through April. The average pending workload of such bills has been reduced at a steady pace and as of April 30, was down to 1.4 million bills on hand.

Although these reductions in bill-processing time are gratifying, neither the Social Security Administration or the intermediaries and carriers can be satisfied until they are reduced still further.

Early in January, all social security district offices issued an invitation to Medicare beneficiaries to seek district office assistance in filling out their claims. This made a significant contribution to the reduction in processing time, as is evidenced by the fact that now the carriers find it necessary to return to beneficiaries less than 5 percent of claims received for additional information as against 30–40 percent in the early days of the program.

FUTURE OUTLOOK

To assure the successful start of the vast Medicare program, the Social Security Administration and its contracting intermediaries and carriers had to establish a major new health insurance program and, in so doing, deal with unprecedented administrative and procedural problems. As Medicare goes into its second year, a sound base has been laid from which additional procedural and policy improvements can be made.

In a few areas, where difficulties in program administration persist—the provisions for payment of outpatient and hospital-based physicians' services in the hospital insurance program—legislation proposed by the President should, if enacted, make for smoother operations.

Medicare has taken its place in the mainstream of health care financing for a significant segment of the population. The social security method for the financing of hospital insurance and the voluntary premium paying method for financing the medical insurance part of the program both assure the future fiscal soundness of Medicare.

Medicare, covering an unprecedented spectrum of insured services—inpatient and outpatient hospital benefits, physicians' services in the home, hospital, office, or extended-care facility, the home health agency and nursing home benefits—will be a benchmark for future health insurance plans offered by the private sector for all age groups.

And Medicare, paying full reasonable cost of providing institutional care to program beneficiaries and the full reasonable charge for physician services, is making and will continue to make a significant contribution to the expansion and upgrading of health care facilities and services available to the entire population.